

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

# MISSOURI STATE BOARD OF HEALTH BUREAU OF VITAL STATISTICS CERTIFICATE OF DEATH

Do not use this space.

22936

## 1. PLACE OF DEATH

County Wernier  
Township Washington  
City Washington

Registration District No. 875  
Primary Registration District No. 6162

File No. 16  
Registered No. \_\_\_\_\_  
St. \_\_\_\_\_ Ward \_\_\_\_\_

## 2. FULL NAME

(a) Residence, No. Jessie Simon  
(Usual place of abode) State Hospital #3, St. Ward \_\_\_\_\_

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>F</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>July 27, 1884</u>		
7. AGE YEARS <u>49</u>	MONTHS <u>10</u>	DAYS <u>16</u> If LESS than 1 day, _____ hrs. or _____ min.

OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <u>Housewife</u>
	9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. _____
	10. Date deceased last worked at this occupation (month and year) _____
	11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) Mo.  
(STATE OR COUNTRY)

13. NAME Steve Hubbey

14. BIRTHPLACE (CITY OR TOWN) Mo.  
(STATE OR COUNTRY)

15. MAIDEN NAME Jane Simmons

16. BIRTHPLACE (CITY OR TOWN) Mo.  
(STATE OR COUNTRY)

17. INFORMANT State Hospital #3  
(ADDRESS) Wernier, Mo.

18. BURIAL, CREMATION, OR REMOVAL  
PLACE Wash City Mo. DATE July 12, 1934

19. UNDERTAKER Wash City Undertaking Co.  
(ADDRESS) Wash City Mo.

20. FILED June 12, 1934 W. M. H. H. H.  
Registrar.

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 12, 1934

22. I HEREBY CERTIFY, That I attended deceased from Nov. 12, 1931, to June 12, 1934

I last saw her alive on June 12, 1934. Death is said to have occurred on the date stated above, at 9:10 a.m.

The principal cause of death and related causes of importance were as follows:

Date of onset

General paralysis of the brain  
83  
Other contributory causes of importance:  
lues

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
What test confirmed diagnosis clinical Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_  
Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? no  
If so, specify \_\_\_\_\_

(Signed) Arthur S. Smith, M. D.

(Address) State Hospital #3

